HEALTH EDUCATION AND RISK REDUCTION SERVICES

Effective Date: 11-07-2020

I. PURPOSE

The purpose is to define and provide guidance as to what is allowable for the Health Education and Risk Reduction Services category of service, in accordance with HRSA standards.

II. DEFINITION

Support for Health Education and Risk Reduction Services is designed to educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics may include:

- Education on risk reduction strategies on how to reduce the risk of transmission. Counseling on how to improve their health status and reduce the risk of HIV transmission to others. Providing information such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention.
- Education on health care coverage options (e.g., qualified health plans through the marketplace, Medicaid coverage, Medicare coverage).
- Health literacy
- Treatment adherence education

See also Early Intervention Services

III. PROCEDURE AND PROGRAM GUIDANCE

Health Education/Risk Reduction services cannot be delivered anonymously.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Alabama Department of Health Direct Care Management and Service Branch Service Standards for HIV infected persons, including the following:

1. Intake and Eligibility National Monitoring Standards:

Eligibility determination process requiring documentation in client medical records of low-income status and eligibility based on a specified percent of the FPL and proof of an individual's HIV-positive status, residency. Determination and documentation of client e eligibility every six months.[3]

Health Resources and Services Administration (HRSA), the funder for Ryan White HIV Services, prohibits continued HIV services, including medications to clients who are not recertified for eligibility of services by their specified date; therefore, if a client has not completed their annual certification or recertification at six months they may not be eligible for Ryan White services.[3]

Standard	Measure
Referral	
1.1) Referral for Health Education Risk Reduction Services by a Part B Provider is documented prior to initiation of the service.	1.1) Documentation of referral for Health education Risk reduction Services is present in the client's record, signed and dated by provide
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined	1.2) Documentation of the client's eligibility is present in the client's record
1.2) To be eligible for this service applicants must: a) Have an HIV diagnosis b) Live in Alabama c) Apply through the through agency's financial services. d) Have an individual or family income at or below 400% of the Federal Poverty Level (FPL). e) Not qualify for or have Medicaid. f) Provide proof of income, changes in insurance coverage, or any changes in residency every six months for recertification. All clients that file taxes must submit their most current 1040 tax return forms as proof of income. g) Agree to participate in the insurance option that best meets the client's medical needs and for which the client is eligible.	1.3) Documentation is present in files that ensures: a) Client is diagnosed with HIV b) Client Lives in Alabama c) Client meets income guidelines d) Client does not qualify for or currently have Medicaid e) Recertification for continued eligibility for Part B services every six months f) Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible g) The Part B Program is the payer of last resort. This is interpreted as "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made..." by another payment source.[4]
Intake	
1.4) Eligibility screening and intake to be completed within 15 days of initial contact with client	1.4) Documentation of intake, eligibility screening in client record signed and dated by the provide
Recertification	
1.5) Client must be certified every six months at clients half birth month date to continue to receive Ryan White services. There is no grace period.	1.5) Documentation of recertification of the client's eligibility every six months is present in the client's record

1. Key Services Components and Activities

National Monitoring Standards: Health Education/Risk Reduction (HE/RR) services educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission, including: 1) Provision of information about available medical and psychosocial support services, 2) Education on HIV transmission and how to reduce the risk of transmission, and 3) Counseling on how to improve their health status and reduce the risk of HIV transmission to others.[5]

Standard	Measure
Assessment/Service Plan/Provision of Services	
2.0) An initial health education/risk reduction assessment is completed prior to the initiation of the HE/RR plan.	2.0) Documentation of assessment in client's record signed and dated by health educator.
2.1) Within 30 days of initial assessment, and HE/RR plan is developed for each eligible client and signed by the health educator The plan should include: • Goals • Expected outcomes • Actions taken to achieve each goal • Person responsible for completing each action • Target date for completion of each action	2.1) HE/RR plan, documented in client record, signed and dated by the client and health educator
2.2) HE/RR plan is reassessed every 90 days to assess client progress and identify emerging needs	2.2) Documentation of review and update of HE/RR plan as appropriate signed and dated by client and health educator
2.3) Clients living with HIV are educated about HIV transmission and how to reduce the risk of HIV transmission	2.3) Documentation that clients served under this category are educated about HIV transmission and how to reduce the risk of HIV transmission to others. Includes description of
2.3) Clients living with HIV are educated about HIV transmission and how to reduce the risk of HIV transmission	2.3) Documentation that clients served under this category are educated about HIV transmission and how to reduce the risk of HIV transmission to others. Includes description of the types of information, education, and counseling provided to client
2.4) Clients living with HIV are provided information about available medical and psychosocial support services	2.4) Documentation that clients served under this category receive information about available medical and psychosocial support services. Includes description of the types of information, education, and counseling provided to clients

2.5) Clients living with HIV receive counseling on how to improve their health status and reduce the risk of HIV transmission to other	2.5) Documentation that clients served under this category receive counseling on how to improve their health status and reduce the risk of transmission to others. Includes description of the types of information, education, and counseling provided to clients
2.6) Refer client to other services as appropriate, e.g. mental health, substance abuse treatment.	2.6) Documentation of referrals in client's record
Transition and Discharge	
2.7) Client discharged when HE/RR services are no longer needed, goals have been met, upon death or due to safety issues. (see 2.8) Prior to discharge: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter must be sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider. Documentation: Client's record must include: • Date services began • Special client needs • Services needed/actions taken, if applicable • Date of discharge • Reason(s) for discharge • Referrals made at time of discharge, if applicable Transfer: If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.	2.7) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.

Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a threemonth period after first attempt. A certified letter must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If client reports that services are no longer needed or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by the leadership according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart	

Case Closure	
2.8) Case will be closed if client: • Has met the service goals; • Decides to transfer to another agency; • Needs are more appropriately addressed in other programs; • Moves out of state; • Fails to provide updated documentation of eligibility status thus, no longer eligible for services; • Fails to maintain contact with the insurance assistance staff for a period of three months despite three (3) documented attempts to contact client; • Can no longer be located; • Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; • Exhibits pattern of abuse as defined by agency's policy. • Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or • Is deceased.	2.8) Documentation of case closure in client's record with clear rationale for closure.

NOTE: For Clinical Quality Management measures see Appendix D: HRSA HAB National Monitoring Standards, HRSA HAB Core Performance Measures Portfolio and Core Measures links below. These sources provide details and supportive information for CQM program expectations for the recipient and provider subrecipients.

HRSA HAB Core Performance Measures Portfolio: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

HRSA HAB Core Performance Measures link: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/coremeasures.pdf

References

1. HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18)

2. HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April 2013), p. 23.

3. HRSA/HAB Ryan White HIV/AIDS Program Services: Clarifications on Ryan White Program Eligibility Determinations and Recertification Requirements Policy Clarification Notice #13-02

4. Public Health Service Act; Sections 2605(a)(6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (i).

5. HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April 2013), pp. 30-31.

APPENDIX D: HIV/AIDS BUREAU, DIVISION OF STATE HIV/AIDS PROGRAMS NATIONAL MONITORING STANDARDS FOR RYAN WHITE PART B GRANTEES: PROGRAM – PART B

Quality Management

National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.

Standard	Measure
1.1) Measure and report client health outcomes using Medical Nutrition Therapy service measures approved by ADPH	1.1) Performance measurement data on the following indicators: • Percentage of people living with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, who will have at least two care markers in a 6-month period of the 24-month measurement period, occurring at least 60 days apart. (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program living with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

HRSA HAB National Monitoring Standards link: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf